Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Certification and Authorization

I CERTIFY THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE THIS HEALTHCARE FACILITY/PROVIDER TO RELEASE MEDICAL INFORMATION PERTINENT TO THIS OCCUPATIONAL HEALTH SERVICE, EXCEPT INFORMATION RELATED TO THE DIAGNOSIS AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCE, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION.

IF I AM REQUIRED TO COMPLETE A URINE DRUG SCREEN, I UNDERSTAND THAT I MUST REMAIN IN THE FACILITY AND HAVE UP TO THREE HOURS TO PROVIDE AN ADEQUATE SAMPLE TO COMPLETE THE TEST. LEAVING THE FACILITY FOR ANY REASON WILL RESULT IN NOTIFICATION TO MY CURRENT OR PROSPECTIVE EMPLOYER OF MY FAILURE TO COMPLETE THE TEST.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_